Breast and Cervical Cancer Early Detection Program (NBCCEDP) is a federally-funded initiative that provides access to breast and cervical cancer early detection services to low-income and underserved women.

Breast cancer is the second leading cause of cancer-related death among American women. Sadly, one in every eight American women—an estimated 200,000 women this year alone—will be diagnosed with breast cancer according to the Susan G. Komen Breast Cancer Foundation. The American Cancer Society reports in ''Breast Cancer Facts and Figures 2005–2006'' that 40,410 women lost their fights with breast cancer last year. In 2007, the American Cancer Society estimates that 11,150 cases of cervical cancer will be diagnosed and about 3,670 women will lose the battle with cervical cancer this year alone. More must be done to provide access to early detection programs that have the potential to greatly reduce these staggering numbers.

The NBCCEDP provides breast examinations, mammograms, pap smears, and a number of other services to women who fall at or below 250 percent of the Federal poverty level. To date, this successful program has served nearly three million women and diagnosed more than 29,000 breast cancers and 1,800 cervical cancers. Access to early detection medical services is an important step in battling breast and cervical cancers.

As the Chair of the Congressional Asian Pacific American Caucus' Health Task Force, I am acutely aware of the high rates of cancer infections present in the Asian and Pacific Islander American communities. For instance, breast cancer is also the leading cause of cancer death for Filipino-American women, and cervical cancer strikes Vietnamese American women five times more often than Caucasian women, according to the Asian and Pacific Islander American Health Forum. I am also all too aware of the disparities that exist for and the challenges that must be overcome by women from minority communities in order to gain access to screening and diagnostic services for breast and cervical cancer. The CDC reports that the number of new breast cancer diagnoses over the last ten years has remained stable or decreased significantly within ethnic groups other than Asian and Pacific Islander American. The prevalence of breast cancer diagnoses in the Asian and Pacific Islander American, however, has increased during the last 10 years.

On Guam, we have a shortage of oncology-related services. There is no radiology treatment center on Guam. Our only oncologist recently left the island. Cancer early detection is an even higher priority for the people of Guam in light of the challenges we face each day toward gaining better access to cancer diagnosis for those who may be at risk, better treatment for those battling the disease, and better long-term care for those who are survivors.

As someone who knows firsthand the impact that breast and cervical cancer can have on a family, I urge my colleagues to support this important legislation and ensure that we make early detection and diagnosis of breast and cervical cancer a national priority.

Mr. PALLONE. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. PALLONE) that the House suspend the rules and pass the bill, H.R. 1132, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

TRAUMA CARE SYSTEMS PLANNING AND DEVELOPMENT ACT OF 2007

Mr. GENE GREEN of Texas. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 727) to amend the Public Health Service Act to add requirements regarding trauma care, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 727

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Trauma Care Systems Planning and Development Act of 2007''.

SEC. 2. ESTABLISHMENT.

Section 1201 of the Public Health Service Act (42 U.S.C. 300d) is amended to read as follows:

''SEC. 1201. ESTABLISHMENT.

''(a) IN GENERAL.—The Secretary shall, with respect to trauma care—

''(1) conduct and support research, training, evaluations, and demonstration projects;

''(2) foster the development of appropriate, modern systems of such care through the sharing of information among agencies and individuals involved in the study and provision of such care;

''(3) collect, compile, and disseminate information on the achievements of, and problems experienced by, State and local agencies and private entities in providing trauma care and emergency medical services and, in so doing, give special consideration to the unique needs of rural areas;

''(4) provide to State and local agencies technical assistance to enhance each State's capability to develop, implement, and sustain the trauma care component of each State's plan for the provision of emergency medical services;

''(5) sponsor workshops and conferences; and

''(6) promote the collection and categorization of trauma data in a consistent and standardized manner.

''(b) GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS.—The Secretary may make grants, and enter into cooperative agreements and contracts, for the purpose of carrying out subsection (a).''.

SEC. 3. CLEARINGHOUSE ON TRAUMA CARE AND EMERGENCY MEDICAL SERVICES.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended—

(1) by striking section 1202; and

(2) by redesignating section 1203 as section 1202.

SEC. 4. ESTABLISHMENT OF PROGRAMS FOR IMPROVING TRAUMA CARE IN RURAL AREAS.

Section 1202 of the Public Health Service Act, as redesignated by section 3(2), is amended to read as follows:

''SEC. 1202. ESTABLISHMENT OF PROGRAMS FOR IMPROVING TRAUMA CARE IN RURAL AREAS.

''(a) IN GENERAL.—The Secretary may make grants to public and nonprofit private entities for the purpose of carrying out research and demonstration projects with respect to improving the availability and quality of emergency medical services in rural areas—

''(1) by developing innovative uses of communications technologies and the use of new communications technology;

''(2) by developing model curricula, such as advanced trauma life support, for training emergency medical services personnel, including first responders, emergency medical technicians, emergency nurses and physicians, and paramedics—

''(A) in the assessment, stabilization, treatment, preparation for transport, and resuscitation of seriously injured patients, with special attention to problems that arise during long transports and to methods of minimizing delays in transport to the appropriate facility; and

''(B) in the management of the operation of the emergency medical services system;

''(3) by making training for original certification, and continuing education, in the provision and management of emergency medical services more accessible to emergency medical personnel in rural areas through telecommunications, home studies, providing teachers and training at locations accessible to such personnel, and other methods;

''(4) by developing innovative protocols and agreements to increase access to prehospital care and equipment necessary for the transportation of seriously injured patients to the appropriate facilities;

''(5) by evaluating the effectiveness of protocols with respect to emergency medical services and systems; and

''(6) by increasing communication and coordination with State trauma systems.

''(b) SPECIAL CONSIDERATION FOR CERTAIN RURAL AREAS.—In making grants under subsection (a), the Secretary shall give special consideration to any applicant for the grant that will provide services under the grant in any rural area identified by a State under section 1214(d)(1).

''(c) REQUIREMENT OF APPLICATION.—The Secretary may not make a grant under subsection (a) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.''.

SEC. 5. COMPETITIVE GRANTS.

Part A of title XII of the Public Health Service Act, as amended by section 3, is amended by adding at the end the following:

''SEC. 1203. COMPETITIVE GRANTS FOR THE IMPROVEMENT OF TRAUMA CARE.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to States, political subdivisions, or consortia of States or political subdivisions for the purpose of improving access to and enhancing the development of trauma care systems.

''(b) USE OF FUNDS.—The Secretary may make a grant under this section only if the applicant agrees to use the grant—

''(1) to integrate and broaden the reach of a trauma care system, such as by developing innovative protocols to increase access to prehospital care;

''(2) to strengthen, develop, and improve an existing trauma care system;

''(3) to expand communications between the trauma care system and emergency medical services through improved equipment or a telemedicine system;

''(4) to improve data collection and retention; or

''(5) to increase education, training, and technical assistance opportunities, such as training and continuing education in the management of emergency medical services accessible to emergency medical personnel in rural areas through telehealth, home studies, and other methods.

''(c) PREFERENCE.—In selecting among States, political subdivisions, and consortia of States or political subdivisions for purposes of making grants under this section, the Secretary shall give preference to applicants that—

''(1) have developed a process, using national standards, for designating trauma centers;

''(2) recognize protocols for the delivery of seriously injured patients to trauma centers;

''(3) implement a process for evaluating the performance of the trauma system; and

''(4) agree to participate in information systems described in section 1202 by collecting, providing, and sharing information.

''(d) PRIORITY.—In making grants under this section, the Secretary shall give priority to applicants that will use the grants to focus on improving access to trauma care systems.

''(e) SPECIAL CONSIDERATION.—In awarding grants under this section, the Secretary shall give special consideration to projects that demonstrate strong State or local support, including availability of non-Federal contributions.''.

SEC. 6. REQUIREMENT OF MATCHING FUNDS FOR FISCAL YEARS SUBSEQUENT TO FIRST FISCAL YEAR OF PAYMENTS.

Section 1212 of the Public Health Service Act (42 U.S.C. 300d–12) is amended to read as follows:

''SEC. 1212. REQUIREMENT OF MATCHING FUNDS FOR FISCAL YEARS SUBSEQUENT TO FIRST FISCAL YEAR OF PAYMENTS.

''(a) NON-FEDERAL CONTRIBUTIONS.—

''(1) IN GENERAL.—The Secretary may not make payments under section 1211(a) unless the State involved agrees, with respect to the costs described in paragraph (2), to make available non-Federal contributions (in cash or in kind under subsection (b)(1)) toward such costs in an amount that—

''(A) for the second and third fiscal years of such payments to the State, is not less than $1 for each $1 of Federal funds provided in such payments for such fiscal years; and

''(B) for the fourth and subsequent fiscal years of such payments to the State, is not less than $2 for each $1 of Federal funds provided in such payments for such fiscal years.

''(2) PROGRAM COSTS.—The costs referred to in paragraph (1) are—

''(A) the costs to be incurred by the State in carrying out the purpose described in section 1211(b); or

''(B) the costs of improving the quality and availability of emergency medical services in rural areas of the State.

''(3) INITIAL YEAR OF PAYMENTS.—The Secretary may not require a State to make non-Federal contributions as a condition of receiving payments under section 1211(a) for the first fiscal year of such payments to the State.

''(b) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—With respect to compliance with subsection (a) as a condition of receiving payments under section 1211(a)—

''(1) a State may make the non-Federal contributions required in such subsection in cash or in kind, fairly evaluated, including plant, equipment, or services; and

''(2) the Secretary may not, in making a determination of the amount of non-Federal contributions, include amounts provided by the Federal Government or services assisted or subsidized to any significant extent by the Federal Government.''.

SEC. 7. REQUIREMENTS WITH RESPECT TO CARRYING OUT PURPOSE OF ALLOTMENTS.

Section 1213 of the Public Health Service Act (42 U.S.C. 300d–13) is amended to read as follows:

''SEC. 1213. REQUIREMENTS WITH RESPECT TO CARRYING OUT PURPOSE OF ALLOTMENTS.

''(a) TRAUMA CARE MODIFICATIONS TO STATE PLAN FOR EMERGENCY MEDICAL SERVICES.—With respect to the trauma care component of a State plan for the provision of emergency medical services, the modifications referred to in section 1211(b) are such modifications to the State plan as may be necessary for the State involved to ensure that the plan provides for access to the highest possible quality of trauma care, and that the plan—

''(1) specifies that the modifications required pursuant to paragraphs (2) through (11) will be implemented by the principal State agency with respect to emergency medical services or by the designee of such agency;

''(2) specifies a public or private entity that will designate trauma care regions and trauma centers in the State;

''(3) subject to subsection (b), contains national standards and requirements of the American College of Surgeons or another appropriate entity for the designation of level I and level II trauma centers, and in the case of rural areas level III trauma centers (including trauma centers with specified capabilities and expertise in the care of pediatric trauma patients), by such entity, including standards and requirements for—

''(A) the number and types of trauma patients for whom such centers must provide care in order to ensure that such centers will have sufficient experience and expertise to be able to provide quality care for victims of injury;

''(B) the resources and equipment needed by such centers; and

''(C) the availability of rehabilitation services for trauma patients;

''(4) contains standards and requirements for the implementation of regional trauma care systems, including standards and guidelines (consistent with the provisions of section 1867 of the Social Security Act) for medically directed triage and transportation of trauma patients (including patients injured in rural areas) prior to care in designated trauma centers;

''(5) subject to subsection (b), contains national standards and requirements, including those of the American Academy of Pediatrics and the American College of Emergency Physicians, for medically directed triage and transport of severely injured children to designated trauma centers with specified capabilities and expertise in the care of pediatric trauma patients;

''(6) utilizes a program with procedures for the evaluation of designated trauma centers (including trauma centers described in paragraph (5)) and trauma care systems;

''(7) provides for the establishment and collection of data in accordance with data collection requirements developed in consultation with surgical, medical, and nursing specialty groups, State and local emergency medical services directors, and other trained professionals in trauma care, from each designated trauma center in the State of a central data reporting and analysis system—

''(A) to identify the number of severely injured trauma patients and the number of deaths from trauma within trauma care systems in the State;

''(B) to identify the cause of the injury and any factors contributing to the injury;

''(C) to identify the nature and severity of the injury;

''(D) to monitor trauma patient care (including prehospital care) in each designated trauma center within regional trauma care systems in the State (including relevant emergency-department discharges and rehabilitation information) for the purpose of evaluating the diagnosis, treatment, and treatment outcome of such trauma patients;

''(E) to identify the total amount of uncompensated trauma care expenditures for each fiscal year by each designated trauma center in the State; and

''(F) to identify patients transferred within a regional trauma system, including reasons for such transfer and the outcomes of such patients;

''(8) provides for the use of procedures by paramedics and emergency medical technicians to assess the severity of the injuries incurred by trauma patients;

''(9) provides for appropriate transportation and transfer policies to ensure the delivery of patients to designated trauma centers and other facilities within and outside of the jurisdiction of such system, including policies to ensure that only individuals appropriately identified as trauma patients are transferred to designated trauma centers, and to provide periodic reviews of the transfers and the auditing of such transfers that are determined to be appropriate;

''(10) conducts public education activities concerning injury prevention and obtaining access to trauma care;

''(11) coordinates planning for trauma systems with State disaster emergency planning and bioterrorism hospital preparedness planning; and

''(12) with respect to the requirements established in this subsection, provides for coordination and cooperation between the State and any other State with which the State shares any standard metropolitan statistical area.

''(b) CERTAIN STANDARDS WITH RESPECT TO TRAUMA CARE CENTERS AND SYSTEMS.—

''(1) IN GENERAL.—The Secretary may not make payments under section 1211(a) for a fiscal year unless the State involved agrees that, in carrying out paragraphs (3) through (5) of subsection (a), the State will adopt standards for the designation of trauma centers, and for triage, transfer, and transportation policies, and that the State will, in adopting such standards—

''(A) take into account national standards that outline resources for optimal care of injured patients;

''(B) consult with medical, surgical, and nursing speciality groups, hospital associations, emergency medical services State and local directors, concerned advocates, and other interested parties;

''(C) conduct hearings on the proposed standards after providing adequate notice to the public concerning such hearing; and

''(D) beginning in fiscal year 2008, take into account the model plan described in subsection (c).

''(2) QUALITY OF TRAUMA CARE.—The highest quality of trauma care shall be the primary goal of State standards adopted under this subsection.

''(3) APPROVAL BY THE SECRETARY.—The Secretary may not make payments under section 1211(a) to a State if the Secretary determines that—

''(A) in the case of payments for fiscal year 2008 and subsequent fiscal years, the State has not taken into account national standards, including those of the American College of Surgeons, the American College of Emergency Physicians, and the American Academy of Pediatrics, in adopting standards under this subsection; or

''(B) in the case of payments for fiscal year 2008 and subsequent fiscal years, the State has not, in adopting such standards, taken into account the model plan developed under subsection (c).

''(c) MODEL TRAUMA CARE PLAN.—

''(1) IN GENERAL.—Not later than 1 year after the date of the enactment of the Trauma Care Systems Planning and Development Act of 2007, the Secretary shall update the model plan for the designation of trauma centers and for triage, transfer, and transportation policies that may be adopted for guidance by the State. Such plan shall—

''(A) take into account national standards, including those of the American College of Surgeons, American College of Emergency Physicians, and the American Academy of Pediatrics;

''(B) take into account existing State plans;

''(C) be developed in consultation with medical, surgical, and nursing speciality groups, hospital associations, emergency medical services State directors and associations, and other interested parties; and

''(D) include standards for the designation of rural health facilities and hospitals best able to receive, stabilize, and transfer trauma patients to the nearest appropriate designated trauma center, and for triage, transfer, and transportation policies as they relate to rural areas.

''(2) APPLICABILITY.—Standards described in paragraph (1)(D) shall be applicable to all rural areas in the State, including both non-metropolitan areas and frontier areas that have populations of less than 6,000 per square mile.

''(d) RULE OF CONSTRUCTION WITH RESPECT TO NUMBER OF DESIGNATED TRAUMA CENTERS.—With respect to compliance with subsection (a) as a condition of the receipt of a grant under section 1211(a), such subsection may not be construed to specify the number of trauma care centers designated pursuant to such subsection.''.

SEC. 8. REQUIREMENT OF SUBMISSION TO SECRETARY OF TRAUMA PLAN AND CERTAIN INFORMATION.

Section 1214 of the Public Health Service Act (42 U.S.C. 300d–14) is amended to read as follows:

''SEC. 1214. REQUIREMENT OF SUBMISSION TO SECRETARY OF TRAUMA PLAN AND CERTAIN INFORMATION.

''(a) IN GENERAL.—For each fiscal year, the Secretary may not make payments to a State under section 1211(a) unless, subject to subsection (b), the State submits to the Secretary the trauma care component of the State plan for the provision of emergency medical services, including any changes to the trauma care component and any plans to address deficiencies in the trauma care component.

''(b) INTERIM PLAN OR DESCRIPTION OF EFFORTS.—For each fiscal year, if a State has not completed the trauma care component of the State plan described in subsection (a), the State may provide, in lieu of such completed component, an interim component or a description of efforts made toward the completion of the component.

''(c) INFORMATION RECEIVED BY STATE REPORTING AND ANALYSIS SYSTEM.—The Secretary may not make payments to a State under section 1211(a) unless the State agrees that the State will, not less than once each year, provide to the Secretary the information received by the State pursuant to section 1213(a)(7).

''(d) AVAILABILITY OF EMERGENCY MEDICAL SERVICES IN RURAL AREAS.—The Secretary may not make payments to a State under section 1211(a) unless—

''(1) the State identifies any rural area in the State for which—

''(A) there is no system of access to emergency medical services through the telephone number 911;

''(B) there is no basic life-support system; or

''(C) there is no advanced life-support system; and

''(2) the State submits to the Secretary a list of rural areas identified pursuant to paragraph (1) or, if there are no such areas, a statement that there are no such areas.''.

SEC. 9. RESTRICTIONS ON USE OF PAYMENTS.

Section 1215 of the Public Health Service Act (42 U.S.C. 300d–15) is amended to read as follows:

''SEC. 1215. RESTRICTIONS ON USE OF PAYMENTS.

''(a) IN GENERAL.—The Secretary may not, except as provided in subsection (b), make payments under section 1211(a) for a fiscal year unless the State involved agrees that the payments will not be expended—

''(1) for any purpose other than developing, implementing, and monitoring the modifications required by section 1211(b) to be made to the State plan for the provision of emergency medical services;

''(2) to make cash payments to intended recipients of services provided pursuant to this section;

''(3) to purchase or improve real property (other than minor remodeling of existing improvements to real property);

''(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or

''(5) to provide financial assistance to any entity other than a public or nonprofit private entity.

''(b) WAIVER.—The Secretary may waive a restriction under subsection (a) only if the Secretary determines that the activities outlined by the State plan submitted under section 1214(a) by the State involved cannot otherwise be carried out.''.

SEC. 10. REQUIREMENTS OF REPORTS BY STATES.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by striking section 1216.

SEC. 11. REPORT BY SECRETARY.

Section 1222 of the Public Health Service Act (42 U.S.C. 300d–22) is amended to read as follows:

''SEC. 1222. REPORT BY SECRETARY.

''Not later than October 1, 2008, the Secretary shall report to the appropriate committees of Congress on the activities of the States carried out pursuant to section 1211. Such report shall include an assessment of the extent to which Federal and State efforts to develop systems of trauma care and to designate trauma centers have reduced the incidence of mortality, and the incidence of permanent disability, resulting from trauma. Such report may include any recommendations of the Secretary for appropriate administrative and legislative initiatives with respect to trauma care.''.

SEC. 12. FUNDING.

Section 1232 of the Public Health Service Act (42 U.S.C. 300d–32) is amended to read as follows:

''SEC. 1232. FUNDING.

''(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out parts A and B, subject to subsections (b) and (c), there are authorized to be appropriated $12,000,000 for fiscal year 2008, $10,000,000 for fiscal year 2009, and $8,000,000 for each of the fiscal years 2010 through 2012.

''(b) RESERVATION OF FUNDS.—If the amount appropriated under subsection (a) for a fiscal year is equal to or less than $1,000,000, such appropriation is available only for the purpose of carrying out part A. If the amount so appropriated is greater than $1,000,000, 50 percent of such appropriation shall be made available for the purpose of carrying out part A and 50 percent shall be made available for the purpose of carrying out part B.

''(c) ALLOCATION OF PART A FUNDS.—Of the amounts appropriated under subsection (a) for a fiscal year to carry out part A—

''(1) 10 percent of such amounts for such year shall be allocated for administrative purposes; and

''(2) 10 percent of such amounts for such year shall be allocated for the purpose of carrying out section 1202.''.

SEC. 13. RESIDENCY TRAINING PROGRAMS IN EMERGENCY MEDICINE.

Section 1251 of the Public Health Service Act (42 U.S.C. 300d–51) is amended to read as follows:

''SEC. 1251. RESIDENCY TRAINING PROGRAMS IN EMERGENCY MEDICINE.

''(a) IN GENERAL.—The Secretary may make grants to public and nonprofit private entities for the purpose of planning and developing approved residency training programs in emergency medicine.

''(b) IDENTIFICATION AND REFERRAL OF DOMESTIC VIOLENCE.—The Secretary may make a grant under subsection (a) only if the applicant involved agrees that the training programs under subsection (a) will provide education and training in identifying and referring cases of domestic violence.

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $400,000 for each of the fiscal years 2008 though 2012.''.

SEC. 14. STATE GRANTS FOR CERTAIN PROJECTS.

Section 1252 of the Public Health Service Act (42 U.S.C. 300d–52) is amended in the section heading by striking ''***demonstration***''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas (Mr. GENE GREEN) and the gentleman from Texas (Mr. BURGESS) each will control 20 minutes.

The Chair recognizes the gentleman from Texas (Mr. GENE GREEN).

GENERAL LEAVE

Mr. GENE GREEN of Texas. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield myself such time as I may consume.

I rise today in support of H.R. 727, legislation to reauthorize the Trauma Systems Planning and Development Act. This program, under the Public Health Service Act, was first authorized in 1990 to improve and coordinate trauma care in our country.

Since then, this program has provided $30 million to States to establish state-wide and regional trauma systems. Injury related to trauma is the leading cause of death for younger Americans, ages 1 through 44. Trauma also causes more than 300,000 permanent disabilities each year.

For seriously injured individuals, the first hour after an injury is when medical care is most effective in saving lives and function. This hour is also often referred to as the ''golden hour,'' during which trauma and emergency systems must respond both quickly and efficiently.

This golden hour is also the goal that our military has for getting medical attention to our soldiers injured on the battlefield. The military has an impressive, streamlined trauma system that my colleagues Dr. BURGESS; our ranking member at that time, Congressman DEAL from Georgia; and our late colleague Dr. Norwood from Georgia and I marveled at during our trip last summer to Iraq, where we toured the military's trauma facilities in Balad.

Unfortunately, the military's trauma system is not replicated in civilian health care, and too many Americans do not benefit from trauma systems that facilitate medical intervention during this critical time frame.

While the death rate from trauma is 50 percent higher in rural areas than in urban locations, trauma affects each corner of this country. In fact, nearly 25 percent of all Americans sustain injuries each year that require medical attention. Yet without coordinated trauma systems and quick access to care, injuries are too often fatal.

In Houston, we learned this lesson the hard way when the lack of trauma

coordination forced a young man to wait more than 4 hours to receive care after he was hit by a car on Halloween night in 2001. With serious head, chest and leg injuries, this patient was clearly medically unstable and should have received immediate care at one of Houston's two level-one trauma centers. But with the trauma centers increasingly on diversion, this young man was transported to Austin where he died the next day.

It was clear that we needed better trauma systems in the Houston area, and we quickly learned that the problem was felt throughout our Nation. We also learned that the effective trauma systems would help prevent nearly 25,000 deaths each year.

As a response, we developed this legislation to build on the program's initial success since 1990, and we authorized it through 2012.

This bill includes changes to the program to ensure that scarce health care dollars go to the communities most in need, ensuring that Federal funds are utilized to strengthen trauma systems and improve communication and coordination among different trauma systems.

It specifically ensures that grants go to States that coordinate planning for trauma systems with State disaster emergency planning and bioterrorism hospital preparedness planning.

In addition, this legislation would require the Secretary to update the model plan for the designation of trauma centers and set triage, transfer, and transportation policies.

The legislation also reauthorizes the Residency Training Program in Emergency Medicine in an effort to ensure an adequate level of ER physicians to treat patients in need of care from America's trauma centers.

I would like to thank Mr. BURGESS from Texas for his leadership on this legislation and for helping to craft the compromise before us today.

I would also like to thank Chairman DINGELL and our Health Subcommittee Chairman PALLONE for their interest in this issue. We have been working on this bill for 5 years.

Until now, this important issue failed to receive the attention it deserved, so I appreciate my chairman including this bill on our first markup in this Congress.

I also appreciate the hard work that John Ford, William Garner and Pete Goodloe of the committee staff put in to guide this bill through the committee to ensure that we have a consensus product to approve today, and also my own staff who has worked on this for at least 3 years.

□ 2030

I also appreciate the support of the American College of Surgeons, the American Osteopathic Association, the American Academy of Pediatrics, the American Association of Neurological Surgeons, the American Trauma Society, the Coalition for American Trauma Care and the Emergency Nurses Association.

The members of these groups are on the front lines and know that coordinated trauma systems can literally save lives. We thank them for all they do for our communities.

I urge my colleagues to vote for this important legislation.

Mr. Speaker, I reserve the balance of my time.

Mr. BURGESS. Mr. Speaker, at this point, I yield such time as he may consume to the gentleman from Louisiana (Mr. BOUSTANY), who has intimate, firsthand knowledge of this issue.

Mr. BOUSTANY. I thank my colleague from Texas for yielding time to me.

Mr. Speaker, prior to coming to Congress, I was a practicing cardiovascular and thoracic surgeon with extensive experience in open heart surgery, as well as trauma surgery. But I want to speak about the importance of this bill not as a physician but as a parent of a son who was in a severe car accident.

About 6 years ago, I will never forget this, this was a Wednesday night, about 11:30 in the evening, and I received a phone call from the hospital from a friend of mine who is an emergency room physician who told me, was your son driving a black Alero? I said, what do you mean, ''was''? He went on to say, ''Well, I think he's going to be okay.'' He started to read off the litany of injuries that my son had.

So I immediately rushed over to the hospital, and I didn't think about it, but I happened to be on call for chest trauma that night, so I was worried that I might have to operate on my own son. I get to the hospital and found out that he was in the emergency room, sitting there for about 3 to 4 hours. He was in shock. There was no organization with regard to prioritization of his injuries.

I immediately jumped in and started kind of prioritizing things, and we managed to get him stabilized. He went through some extensive surgery that night. He subsequently had to be transferred to another hospital 180 miles away for further treatment of his extensive orthopedic injuries.

Because of lack of trauma coordination at that hospital, he developed severe malnutrition, lost about 50 pounds, had a lack of coordination with his antibiotics, developed infections, and spent nearly 6 or 7 weeks in the hospital, followed by about 3 to 4 to 5 months of further care to get him back to where he could walk with crutches. Thankfully now, today, he is doing well.

But if it wouldn't have been for my personal experience as a physician, overseeing the care of my son, he would not have gotten the appropriate care, and that is because we didn't have a coordinated trauma center.

Trauma cannot be fragmented. It requires a coordinated effort by a team of experts.

As was mentioned, the mortality rate from trauma is significantly higher in rural areas than it is in urban areas. There are nearly 20- to 25,000 trauma deaths each year that are preventable if we had the proper coordination.

We have learned much from the military. Much of trauma surgery has evolved from military activity and stream of the wounded afterwards. There have been tremendous advances, but this does not translate to civilian area, where we do not have trauma centers.

Clearly, this is a bill that is important, and I appreciate the committee for bringing this forward and the hard work that has been done.

This bill will ensure that severely injured patients get coordinated care, get care by experts, by a team of experts, not just in the emergency room and the operating room but in the aftermath, where it's so critical to full recovery and full rehabilitation.

This bill will award grants to the States for planning, implementing and developing trauma care systems. The Institute of Medicine has said the availability of Federal funds through the Trauma Care Systems and Planning Development Act appears to have helped increase the number of trauma centers and urged, in 1999, the reauthorization of the Trauma Care Act.

This bill is absolutely necessary. It's critical, and it also will serve to build a trauma registry, which is so important, so that we can catalog these injuries and learn from these things so that we can actually improve trauma care further in the civilian arena.

I urge my colleagues to support this bill. It's a superb bill. It's an excellent bill.

Mr. GENE GREEN of Texas. Mr. Speaker, we reserve the balance of our time.

Mr. BURGESS. Mr. Speaker, as we have just heard, this is an important bill. Trauma is one of the most expensive illnesses that we treat in this country. I am so pleased today to stand in support of H.R. 727, the Trauma Care Systems Planning and Development Act of 2007.

In 1990, the Trauma Care Systems Planning and Development Act created title XII of the Public Health Service Act. This program was borne out of a report in which it was found that severely injured individuals in a majority of both urban and rural areas of the United States were not receiving the benefit of trauma systems, despite considerable evidence that a trauma system would improve survival rates.

H.R. 727 requires the Health Resources and Services Administration to work with each State to help establish advanced trauma life support systems and to train EMS personnel for rural areas. Likewise, the program will help to make improvements in communication and coordination with the larger State trauma systems.

For Americans between the ages of 1 and 44, trauma is the leading cause of death. Traumatic injury in the United States, largely due to motor-related

trauma, totals $260 billion in costs. By reauthorizing this program, we will achieve the goal of ensuring that all areas of the United States have appropriate emergency medical services.

As the legislation is structured, entities, either States or independent agencies, may compete for planning and development grants to help improve the trauma system and coordination in a given region. That is a distinct difference from the trauma bill that existed before.

This bill is an improvement over the previous authorization because it will allow both States and other political subdivisions to work cooperatively to improve trauma systems. This bill also represents a more realistic authorization that will essentially act as start-up Federal funding for enhanced communication, enhanced coordination and data collection for States and other eligible grantees.

Certainly, I need to join my colleague from Texas in thanking Congressman BARTON and Congressman DINGELL for their hard work on this legislation. Mr. Speaker, this has been a work in process for some time.

My personal staff, Josh Martin, worked diligently on this bill last year. There were a number of issues with the other body which took some time to resolve, but happily they were resolved before the end of the year. We are now able to support H.R. 727 in this Congress, get the bill passed and get this coordination of service where it is so badly needed.

Mr. Speaker, I yield back the balance of my time.

Mr. GENE GREEN of Texas. Mr. Speaker, I urge passage of the bill, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. GENE GREEN) that the House suspend the rules and pass the bill, H.R. 727, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

MESSAGE FROM THE SENATE

A message from the Senate by Ms. Curtis, one of its clerks, announced that the Senate has passed bills of the following titles in which the concurrence of the House is requested:

S. 474. An act to award a congressional gold medal to Michael Ellis DeBakey, M.D.

S. 1002. An act to amend the Older Americans Act of 1965 to reinstate certain provisions relating to the nutrition services incentive program.

STROKE TREATMENT AND ONGOING PREVENTION ACT

Mr. PALLONE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 477) to amend the Public Health Service Act to strengthen education, prevention, and treatment programs relating to stroke, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 477

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Stroke Treatment and Ongoing Prevention Act''.

SEC. 2. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT REGARDING STROKE PROGRAMS.

(a) STROKE EDUCATION AND INFORMATION PROGRAMS.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

''PART [R] *S—STROKE EDUCATION, INFORMATION, AND DATA COLLECTION PROGRAMS*

''SEC. [399AA] *399FF*. STROKE PREVENTION AND EDUCATION CAMPAIGN.

''(a) IN GENERAL.—The Secretary shall carry out an education and information campaign to promote stroke prevention and increase the number of stroke patients who seek immediate treatment.

''(b) AUTHORIZED ACTIVITIES.—In implementing the education and information campaign under subsection (a), the Secretary may—

''(1) make public service announcements about the warning signs of stroke and the importance of treating stroke as a medical emergency;

''(2) provide education regarding ways to prevent stroke and the effectiveness of stroke treatment; and

''(3) carry out other activities that the Secretary determines will promote prevention practices among the general public and increase the number of stroke patients who seek immediate care.

''(c) MEASUREMENTS.—In implementing the education and information campaign under subsection (a), the Secretary shall—

''(1) measure public awareness before the start of the campaign to provide baseline data that will be used to evaluate the effectiveness of the public awareness efforts;

''(2) establish quantitative benchmarks to measure the impact of the campaign over time; and

''(3) measure the impact of the campaign not less than once every 2 years or, if determined appropriate by the Secretary, at shorter intervals.

''(d) NO DUPLICATION OF EFFORT.—In carrying out this section, the Secretary shall avoid duplicating existing stroke education efforts by other Federal Government agencies.

''(e) CONSULTATION.—In carrying out this section, the Secretary may consult with organizations and individuals with expertise in stroke prevention, diagnosis, treatment, and rehabilitation.

''SEC. [399BB] *399GG*. PAUL COVERDELL NATIONAL ACUTE STROKE REGISTRY AND CLEARINGHOUSE.

''The Secretary, acting through the Centers for Disease Control and Prevention, shall maintain the Paul Coverdell National Acute Stroke Registry and Clearinghouse by—

''(1) continuing to develop and collect specific data points and appropriate benchmarks for analyzing care of acute stroke patients;

''(2) collecting, compiling, and disseminating information on the achievements of, and problems experienced by, State and local agencies and private entities in developing and implementing emergency medical systems and hospital-based quality of care interventions; and

''(3) carrying out any other activities the Secretary determines to be useful to maintain the Paul Coverdell National Acute Stroke Registry and Clearinghouse to reflect the latest advances in all forms of stroke care.

''SEC. [399CC] *399HH*. STROKE DEFINITION.

''For purposes of this part, the term 'stroke' means a 'brain attack' in which blood flow to the brain is interrupted or in which a blood vessel or aneurysm in the brain breaks or ruptures.

''SEC. [399DD] *399II*. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated to carry out this part $5,000,000 for each of fiscal years 2008 through 2012.''.

(b) EMERGENCY MEDICAL PROFESSIONAL DEVELOPMENT.—Section 1251 of the Public Health Service Act (42 U.S.C. 300d–51) is amended to read as follows:

''SEC. 1251. MEDICAL PROFESSIONAL DEVELOPMENT IN ADVANCED STROKE AND TRAUMATIC INJURY TREATMENT AND PREVENTION.

''(a) RESIDENCY AND OTHER PROFESSIONAL TRAINING.—The Secretary may make grants to public and nonprofit entities for the purpose of planning, developing, and enhancing approved residency training programs and other professional training for appropriate health professions in emergency medicine, including emergency medical services professionals, to improve stroke and traumatic injury prevention, diagnosis, treatment, and rehabilitation.

''(b) CONTINUING EDUCATION ON STROKE AND TRAUMATIC INJURY.—

''(1) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to qualified entities for the development and implementation of education programs for appropriate health care professionals in the use of newly developed diagnostic approaches, technologies, and therapies for health professionals involved in the prevention, diagnosis, treatment, and rehabilitation of stroke or traumatic injury.

''(2) DISTRIBUTION OF GRANTS.—In awarding grants under this subsection, the Secretary shall give preference to qualified entities that will train health care professionals that serve areas with a significant incidence of stroke or traumatic injuries.

''(3) APPLICATION.—A qualified entity desiring a grant under this subsection shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a plan for the rigorous evaluation of activities carried out with amounts received under the grant.

''(4) DEFINITIONS.—For purposes of this subsection:

''(A) The term 'qualified entity' means a consortium of public and private entities, such as universities, academic medical centers, hospitals, and emergency medical systems that are coordinating education activities among providers serving in a variety of medical settings.

''(B) The term 'stroke' means a 'brain attack' in which blood flow to the brain is interrupted or in which a blood vessel or aneurysm in the brain breaks or ruptures.

''(c) REPORT.—Not later than 1 year after the allocation of grants under this section, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on the results of activities carried out with amounts received under this section.